Provider Tax Implementation

As stated above, the language in the State plan amendment detailing the provider assessment is not appropriate for inclusion in the reimbursement section of the State plan (4.19-B). To consider this plan for approval, CMS asks that you delete all references and details of the assessment in the submitted SPA version. However, apart from the reimbursement methodology, we will need to review the details of the provider assessment to ensure compliance with all applicable federal statutory and regulatory requirements. The following questions are intended to solicit additional information regarding the assessment.

Note: CMS deems the "assessment" a provider tax and will henceforth refer to the "assessment" in this RAI as such.

Response

The Department has removed references to the local government assessment from the SPA. A revised State Plan Amendment is attached.

1. The amendment proposes a tax that will be assessed on all privately owned providers of outpatient hospital services within the territorial boundary of a local government. A tax exclusive to privately owned providers of outpatient hospital services within a territorial boundary of a local government does not meet the broad-based requirements established under 42 CFR 433.68(c)(2). This regulation establishes that "if a health care-related tax is imposed by a unit of local government, the tax must extend to all items or services or providers (or to all providers in a class) in the area over which the unit of government has jurisdiction."

   Given the legislative restriction on private providers, the State may request a waiver from CMS of the broad based requirement, pursuant to 42 CFR 433.72(b), to exclude state-owned and non state-owned governmental providers from the tax proposed in this amendment. These waiver requests must be specific to each unit of local government in the State and must include information on the specific tax structure imposed by each unit of government. Please be advised that the earliest date a waiver can be effective is on the first day in the calendar quarter in which the waiver is received by CMS.

   The proposed amendment states that a waiver to exclude from the tax all state-owned government hospitals and non-state owned governmental hospitals that reside within a territorial boundary of a local government has been approved by CMS. CMS has not granted Colorado a waiver of the broad-based requirements established under 42 CFR 433.68(c)(2) for the purposes of this amendment. Nor, to our knowledge, has the State requested such a waiver of these provisions. Please provide documentation

of the formal correspondence between CMS and the State of Colorado granting the waiver.

Response

The Department believes that a misstatement in the original SPA language and this caused the confusion. Instead of reading ". . . a waiver to exclude those providers from the assessment has been approved by CMS . . ." the SPA should have read, ". . . a waiver to exclude those providers from the assessment must be approved by CMS. . ."

No approval of any waiver concerning this SPA has been received by the Department, nor has the Department submitted any such waiver. The language of the SPA was meant to demonstrate that a waiver must be approved by CMS prior to implementing the payment when a private-owned provider and a state-owned provider and/or non state-owned governmental provider exist within the territorial boundary of the unit of local government. That said, since the SPA may not address waivers or the assessment, this language will be removed from the SPA.

Colorado statute defines qualified providers for this proposed payment as "nongovernmental" licensed hospitals. The Department will submit a waiver from the broad-based requirements of the provider tax established under 42 CFR 433.72(b) to exclude state-owned government hospitals and non state-owned government hospitals that reside within the territorial boundary of a unit of local government from the assessment proposed in this amendment, when appropriate.

The Department will submit a separate waiver for each unit of local government where a private-owned hospital and a state-owned and/or non state-owned governmental hospital(s) reside within the territorial boundary of the unit of local government. In the event that a waiver is granted by CMS, where applicable, the Department will use the same general format for each waiver request thereafter.

For the first participant in this Program - Platte Valley Medical Center, which is located in the City of Brighton, Colorado, no waiver will be necessary, as that provider is the sole provider of Outpatient Hospital Services within the unit of local government and is covered under this State Plan Amendment.

Since the first provider in this Program is the sole provider of Outpatient Hospital Services within the participating unit of local government, the Department is also providing information related to the City of Brighton's governing structure, its jurisdictional authority over this provider, the by-laws of Platte Valley Medical Center, and documentation to verify that Platte Valley Medical Center is, indeed, the sole provider of Outpatient Hospital Services within the city limits.

The following items are included in the accompanying packet for review by Office of General Counsel:

- ***City of Brighton Home Rule Charter***
- ***Letter from City of Brighton's General Counsel explaining the city's taxing authority over the hospital***
- ***Printed map of City of Brighton city limits with the location of Platte Valley Medical Center circled. To view and enlarge this map online go to http://www.brightonco.gov/egov/docs/1184277755_742492.pdf***
- ***Verification from the Colorado Department of Public Health and Environment's hospital licensing and certification listings that Platte Valley Medical Center is the only hospital within the City of Brighton. See http://www.hfemsd1.dphe.state.co.us/hfd2003/homebase.aspx?Ftype=hospital&Do=list***
- ***A map of all hospitals in Colorado does not exist. However, the Colorado Hospital Association has provided a listing of hospitals by city. See http://www.cha.com/index.php?option=com_content&task=view&id=45&Itemid=83***
- ***Proposed contract between the State and City of Brighton. As advised by the Department's Contracts and Purschasing Section, the State will enter into agreement via a contract, rather than a Memorandum of Understanding (MOU), as previously indicated.***
- ***By-Laws of Platte Valley Medical Center***
- ***For additional information on Platte Valley Medical Center refer to http://www.pvmc.org***

2. The amendment language detailing the provider tax does not establish that the tax meets the uniformity requirements under 42 CFR 433.68(d). Below, please address each of the following through the formal response to the RAI. (Again, CMS expects the language detailing the provider tax will be removed from the State plan amendment).

    a. The language does not demonstrate that the tax will be a uniform rate for all services (or providers of those items or services) in the class on all gross revenues or receipts, or on net operating revenues relating to the provision of all items or services in the State, unit, or jurisdiction.

Response

The assessment will be a uniform rate on all hospitals that provide outpatient hospital services within the jurisdiction of the unit of local government. Further, the assessment will not exceed 5.5% of net patient revenues for outpatient hospital services less Medicare and Medicaid revenues, as documented in the hospital's most recently audited Medicare/Medicaid Cost Report form 2552-96.

    b. The language does not establish the percentage of revenues that will be assessed by each local unit of government and for each class of service.

Response

Each participating local government will impose an assessment within their territorial boundary not to exceed 5.5% of net patient revenues for outpatient hospital services less Medicare and Medicaid revenues. The percentage assessed on outpatient hospital services may vary between units of local government, but the assessment will be uniform within each unit of local government and will not exceed 5.5% of net patient revenues for outpatient hospital services less Medicare and Medicaid revenues. The Department would like units of local government to have the flexibility to determine their assessment rate, based on their individual circumstances. All participating hospitals within the unit of local government's territorial boundary would be treated uniformly, but each unit of local government may implement the assessment at a different rate.

c. The language establishes that the tax will be a percentage of gross or net revenues of the provider, without specifying which revenue base will be used by each unit of local government and for each class of service.

Response

As directed by CMS, the Department will establish an assessment based on net patient revenues for outpatient hospital services less Medicare and Medicaid outpatient hospital revenues. These revenues will be documented in the most recently audited Medicare/Medicaid Cost Report form 2552-96.

d. The language establishes that the tax may exempt revenue from Medicaid and/or Medicare as determined by the local government. The exclusion of Medicaid and/or Medicare revenues must be applied uniformly to all providers within the class of services and within each unit of local government's local jurisdiction subject to the provider tax.

Response

All participating hospitals within the unit of local government's territorial boundary would be treated uniformly, but each unit of local government may implement the assessment differently. As directed by CMS, the assessment will be based on net patient revenues for outpatient hospital services less Medicare and Medicaid outpatient hospital revenues.

It is the Department's understanding of regulation 433.68(d) that either Medicare or Medicaid revenues, or both, may be excluded from net patient revenues for assessment purposes. The Department has chosen to exclude both for the following reasons: (1) The assessment base is lower, allowing more room under the UPL to maximize provider participation in the program; and (2) The purpose of the payment is to partially compensate Medicaid providers for unreimbursed costs associated with serving Medicaid clients. Excluding Medicaid revenues from the tax base eases the burden on

providers who are serving a proportionately larger share of Medicaid clients. If it is not permissible to exclude <u>both</u> Medicare and Medicaid revenues from the assessment base, the assessment will be revised to exclude only Medicaid revenues.

To aid in addressing the issues above, please provide a listing of each unit of local government that will impose the tax. For each unit of local government include the: imposed tax rate, the taxing base, the class of taxed service(s), a listing of all providers of outpatient hospital services within the unit of local government's jurisdiction, and whether each provider is subject to the tax. CMS will need to independently review each unit of local government and the exact taxing structure to be imposed by each unit of local government.

<u>Response</u>

Participants in the Local Government Outpatient Hospital Payment Program

Unit of Local Government	***City of Brighton, Colorado***
Imposed Assessment (Tax) Rate	***5.5%***
Assessment (Taxing) Base	***Net Patient Revenues Less Medicare and Medicaid Revenues***
Class of Assessment (Tax) Service	***Outpatient Hospital Services***
Providers in Local Jurisdiction	***Platte Valley Medical Center***
Providers Subject to Assessment (Tax)	***Platte Valley Medical Center***

At this time, only one unit of local government is participating in the assessment. Once the State Plan Amendment is approved, the City of Brighton, Colorado will impose the assessment. The only provider of outpatient hospital services within the city's jurisdiction is Platte Valley Medical Center, a private-owned hospital.

3. Within the SPA language, the State indicates that a local jurisdiction may "elect" to assess the tax. Prior to approving a permissible tax, CMS must be aware of all units of local government that will definitively impose the tax. Please explain the use of the term "elect" in the SPA language.

    a. Given that the term "elect" connotes an option to impose the provider tax, how will the State ensure that the provider tax is assessed within each local jurisdiction from year-to-year?

<u>Response</u>

It is not the Department's desire that the SPA would require all units of local government to participate in the assessment. Colorado's statute reads, "Subject to federal Medicaid rules and regulations, in any given year, a local government may elect to not assess the fee imposed on qualified providers." C.R.S. 29-28-103(1)(b)(II) (2006). It should be noted that many of the units of local government in the state do not have a hospital that provides outpatient hospital services. Further, in Colorado, many assessments (taxes) must be first approved by a vote of the citizens. It is not the Department's intent to suggest that the proposed assessment must or must not be

approved by the voters of each unit of local government, as that determination lies with the unit of local government.

Additionally, it is not the Department's intent to mandate that each unit of local government participate in the assessment each year. A unit of local government may find that the assessment is burdensome and may discontinue its participation after participating in the previous year(s).

While the Department does not intend to submit a new SPA for reconsideration each year, the following language has been added as the closing sentence to the SPA. "Each October 1, the State shall submit to CMS a list of providers qualifying for the payment, the payment amounts, the participating local governments and, if necessary, demonstrate that hold harmless provisions have been met." Further, any unit of local government that elects to participate will be required to enter into a contract with the Department and will be required to follow the conditions of the contract and related regulations.

b. Please explain the "certification" process by the county.

Response

This language is used only in the State's legislation from 2006 (Senate Bill 06-145) not the SPA. Local governments will not be certifying local funds and this process is not related to the official "certification of public expenditures" (CPE) process as it is commonly understood. However, the Department will require units of local government to provide documentation to the Department that supports the amount of the assessment and the payment to participating hospital(s) that provide outpatient hospital services within the unit of local government. The Department does not believe this documentation is directly comparable to the CPE used to draw FFP for other payments made within the State Plan.

c. Please also detail the process through which the State will draw FFP and distribute these funds to qualified providers.

Response

The Department will promulgate regulations for the process that units of local government and their hospital(s) that provide outpatient hospital services must follow to receive the payment. The Department will enter into a contract between the State of Colorado and each participating unit of local government to ensure that assessments and payments are made in accordance with the State Plan. Each unit of local government and their hospital(s) that provide outpatient hospital services will provide proper, auditable documentation to the Department. The Department will record the amount of federal share paid to each participating unit of local government on the CMS-64.

Payments will be made to participating providers through their local government. (Senate Bill 06-145 does not allow the Department to make the final payment directly to the provider.) This distribution will be made based on the reimbursement model in the State Plan. Simply stated, this methodology is largely based on the ratio of each individual participating hospital's unreimbursed Medicaid outpatient hospital costs divided by the summation of all unreimbursed Medicaid outpatient hospital costs for all participating hospital(s) within the unit of local government. The Department will have each unit of local government and participating hospital(s) that provide outpatient hospital services submit auditable information to confirm that the assessment occurred and that the final payment was received, as directed by the State, in accordance with the State Plan.

4. Emergency hospital services are not a permissible class for provider taxes under 42 CFR 433.56(a). In order for provider taxes to meet the broad-based requirements in 42 CFR 433.68(c), the tax must apply to all services in a permissible class. Emergency hospital services are considered a subset of outpatient hospital services. Please confirm that taxes will be collected on all outpatient hospital services and will not isolate an impermissible class of emergency hospital services.

Response

The Department does not intend on isolating the provider fee for outpatient hospital services to the subset of emergency hospital services. The provider fee will be assessed on net patient revenues for outpatient hospital services less Medicaid and Medicare outpatient revenues. The Department has edited language in SPA 06-014 to clarify this.

5. Please explain how the proposed tax structure and corresponding reimbursement methodology adheres to the hold harmless provisions under 42 CFR 433.68(f)(2) and (3). Based upon the language in the SPA, it appears that the supplemental payment is contingent upon collection of the provider tax. For each unit of local government, please demonstrate that there is no violation of the indirect hold harmless provisions at 433.68(f)(3)(i).

Response

While the initial participant in this program will be Platte Valley Medical Center, located in the City of Brighton, the Department's hope and intention is that the assessment and corresponding reimbursement methodology proposed in this SPA will apply not only to the City of Brighton and Platte Valley Medical Center, but to all units of local government and participating hospitals who join the program in the future—subject to CMS' current and future approval.

42 CFR 433.68(f)(2) specifies a taxpayer will be held harmless if "all or any portion of the Medicaid payment to the taxpayer varies based only on the amount of the total tax payment." Since the reimbursement is based on a hospital's Unreimbursed Outpatient

Hospital Medicaid Costs, which are not directly related to the assessment base (a hospital's net outpatient hospital patient services revenues minus Medicare and Medicaid outpatient revenues), the methodology adheres to the hold harmless provision under 42 CFR 433.68(f)(2).

42 CFR 433.68(f)(3) states that a hold harmless provision will exist if "the state provides, directly or indirectly, for any payment, offset, or waiver that guarantees to hold taxpayers harmless for all or a portion of the tax." The sole payment returned to participating hospital(s) is the reimbursement amount based on Unreimbursed Outpatient Hospital Medicaid Costs. The State and units of local government will not offer any form of grant, tax credit, waiver, or any other vehicle to offset the assessment amount. Therefore, no hold harmless violation exists under 42 CFR 433.68(f)(3).

Reported Budget Impact

6. The State reports a budget impact of $0 on the CMS SF 179. Given the condition cited under question 3, above, that a State (and CMS) must be aware of the local government(s) that will definitively implement a provider tax prior to CMS approval, please revise the SF 179 to report a budget impact based on those local governments that will implement the tax used to fund supplemental payments under SPA 06-014.

Response

The CMS SF 179 has been updated to reflect the budget impact of the Local Government Payment to Platte Valley Medical Center in Brighton, Colorado. The table below summarizes the derivation of this payment. Please note that this table covers SFY 07-08 as well as SFY 06-07 due to retroactivity.

Step	Estimated Assessment and Payment for Platte Valley Medical Center (Provider)	SFY 06-07	SFY 07-08
	Assessment Calculation		
1	Net Patient Revenues for Outpatient Hospital Services	**$27,456,796**	**$27,456,796**
2	Less Medicare and Medicaid Outpatient Revenues	**$4,997,259**	**$4,997,259**
3	Equals Uninflated Revenue Base (Step 1 minus Step 2)	**$22,459,537**	**$22,459,537**
4	Assessment Base (Step 3 Adjusted for Inflation) [1]	**$26,673,799**	**$27,739,759**
5	Assessment Rate	**5.5%**	**5.5%**
6	Provider Assessment (Step 4 multiplied by Step 5)	**$1,467,059**	**$1,525,687**
7	Total Provider Assessments for All Providers under the Local Government's Authority (only one provider)	**$1,467,059**	**$1,525,687**
8	Total Provider Assessments for All Participating Local Governments (currently only one local government)	**$1,467,059**	**$1,525,687**
9	Local Government's Assessment as a Percentage of All Participating Local Government's Assessments. (Currently only one local government.) (Step 7 divided	**100%**	**100%**

[1] Platte Valley Hospital's most recently audited cost reported was for year 2001. According to the Consumer Price Index ("CPI"), the U.S. city average inflation for Medical Care between years 2001 and 2006 (the most recent full year, used to determine SFY 07-08 calculations) was 23.51%. Similarly, the inflation for Medical Care between years 2001 and 2005 (used to determine calculations for the retroactive period, SFY 06-07 calculations) was 18.76%.

	by Step 8)		
	Payment Calculation		
10	Federal Financial Participation Available under Outpatient Hospital UPL	**$37,788,050**	**$39,251,342**
11	Federal Financial Participation Available to Payment to All Providers under the Local Government's Authority. (Step 9 multiplied by Step 10)	**$37,788,050**	**$39,251,342**
12a	State Share of Payment to All Providers under the Local Government's Authority (Step 8)	**$1,467,059**	**$1,525,687**
12b	Federal Share of Payment to All Providers under the Local Government's Authority (minimum of Step 11 or Step 8.) Federal Share capped by Federal Financial Participation Available to Payment to All Providers under the Local Government's Authority.	**$1,467,059**	**$1,525,687**
12c	Total Amount Available for Payment to All Providers under the Local Government's Authority. (Step 12a plus Step 12b)	**$2,934,118**	**$3,051,374**
	Reimbursement Calculation		
13	Uncompensated Outpatient Hospital Costs	**$342,451**	**$342,451**
14	Inflated Uncompensated Outpatient Hospital Costs (Step 13 Adjusted for Inflation)[1]	**$406,708**	**$422,961**
15	Total Inflated Uncompensated Outpatient Hospital Costs for All Providers under Local Government's Authority (only one provider)	**$406,708**	**$422,961**
16	Percent of Provider Inflated Uncompensated Outpatient Hospital Costs Relative to Total Inflated Uncompensated Outpatient Hospital Costs under the Local Government's Authority. (only one provider) (Step 14 divided by Step 15)	**100%**	**100%**
17	Payment to Provider (Step 16 multiplied by Step 12c)	**$2,934,118**	**$3,051,374**
17a	State Share of Payment to Provider (Step 16 multiplied by Step 12a)	**$1,467,059**	**$1,525,687**
17b	Federal Share of Payment to Provider (Step 16 multiplied by Step 12b)	**$1,467,059**	**$1,525,687**

When another unit of local government chooses to participate in the Local Government Outpatient Hospital payment program, and the Department documents that they are qualified to participate, CMS will be notified through the Department. Please note the closing sentence of the SPA: "Each October 1, the State shall submit to CMS a list of providers qualifying for the payment, the payment amounts, the participating local governments and, if necessary, demonstrate that hold harmless provisions have been met."

Supplemental Payment Reimbursement Methodology

Under the proposed SPA, the identifiable language related to the supplemental reimbursement methodology for outpatient hospital services refers to a calculation derived from providers' unreimbursed costs and contingent upon available funds under the federal upper payment limit for outpatient hospital services and the available of State share. The language indicates that funds available to the local government will be multiplied by the ratio of a provider's unreimbursed Medicaid costs to the unreimbursed Medicaid costs from all qualified providers within a boundary of the local government. The following questions seek to clarify the details of this reimbursement methodology and address language in the SPA that is not comprehensive in accordance with regulation under 42 CFR 447.201 and 447.252.

7. The proposed supplemental payment reimburses for only outpatient hospital services. However, the language in the amendment includes the following Medicaid costs and Medicaid revenues used to calculate the supplemental payment: inpatient hospital

services, outpatient hospital services, emergency hospital services, physician services, prescription drug services, dental services, transportation services, out stationing services and home health services. If the State intends to include all service costs and revenues listed above, please explain how the State justifies including costs and revenues beyond outpatient hospital services as a methodology for an outpatient hospital service supplemental payment.

Response

State statute requires the Department to include, at a minimum, all services referenced in this question as part of unreimbursed Medicaid costs for purposes of redistributing the provider assessments. However, through the direction of CMS, the Department shall limit consideration of unreimbursed Medicaid costs to only unreimbursed outpatient hospital services in the reimbursement methodology for the supplemental payment. This language is documented in the revised SPA submitted with this response.

8. The SPA indicates that all components of Medicaid costs and Medicaid revenues shall be distinctly identifiable on the provider's most recently audited Medicare/Medicaid cost report. Please provide the specific worksheets and lines references on the CMS-2552 that the State intends to use in the reimbursement calculation to determine all Medicaid costs and revenues listed in the reimbursement methodology. By service component, please specify the references used to determine Medicaid costs and revenues. If the State uses worksheets that report Medicare costs and revenues, how will the State use this information to derive Medicaid costs and revenues?

Response

The Department has included a guide below with line references and formulas to illustrate the reimbursement methodology. The following tables illustrate the derivation of costs and revenues for the assessment and reimbursement methodology.

Assessment Base (Relevant Outpatient Revenue)	
Relevant Outpatient Revenue = Gross Outpatient Revenue –Medicare Outpatient Revenue –Medicaid Outpatient Revenue	
Value	***Location in CMS 2552-96***
Gross Outpatient Revenue	Worksheet C, Part I, Column 7, Line 101
Medicare Inpatient Revenue + Medicaid Outpatient Revenue	Worksheet D, Part V, Column 5, Line 101

Reimbursement Base (Uncompensated Medicaid Outpatient Hospital Services)	
Unreimbursed Medicaid Outpatient Hospital Services = $\left(\frac{\text{Total Costs}}{\text{Total Charges}} \times \sum \text{Medicaid Outpatient Charges}\right) - \left(\frac{\text{Total Medicaid Outpatient Charges}}{\text{Total Patient Charges}} \times \text{Total Medicaid Payment}\right)$	
Value	***Location in CMS 2552-96***
Total Costs	Worksheet C, Part I, Column 5, Line 101
Total Charges	Worksheet C, Part I, Column 8, Line 101
Medicaid Outpatient Charges	Title XIX, Worksheet D-4, Column 5, Line 101
Total Inpatient Charges	Worksheet C, Part I, Column 6, Line 101
Total Outpatient Charges	Worksheet C, Part I, Column 7, Line 101
Total Patient Charges	Total Inpatient Charges plus Total Outpatient Charges
Total Medicaid Payments	Title XIX, Worksheet E-3, Part III, Column 1, Line 57

9. The State intends to use Medicaid revenues as reported on the CMS-2552 as part of the calculation of the supplemental reimbursement methodology. Please explain why the State intends to use reported revenues from the cost report rather than actual paid claims to the provider of services from the MMIS.

Response

The Department proposes using the CMS-2552-96 for the following reasons:

- ***costs are audited,***
- ***information will be consistent since the same source can be used to gather cost, charges and revenues data,***
- ***costs are final (due to retroactivity, MMIS data is never "final").***

10. Please explain why the State intends to use the CPI for purposes of trending provider costs and revenues rather than the applicable CMS market basket.

Response

The Department believes that the CPI we have proposed is a better indicator of the health care market for the State. Also, use of this index is consistent with all other provider payment methodologies. However, if directed by CMS, the Department will change the inflation index to the applicable CMS market basket.

11. The SPA language establishes that "a local government shall determine which Medicaid cost and Medicaid revenue components are used to calculate the Local Government Outpatient Hospital payment within the territorial boundary of a local government." This language is subjective, and therefore, does not represent a comprehensive reimbursement methodology that fully describes the payment for which providers will receive. Please delete this language from the SPA. The State must provide specific criteria in the State

plan that defines which Medicaid costs and revenue components will be used by each unit of local government to determine the reimbursement for the supplemental payment.

Response

The original language was intended to allow units of local government flexibility in the development of the payment. However, as directed by CMS, the Department has revised the SPA to eliminate this subjective language and will specify that each unit of local government must use the same distribution methodology. This language is documented in the revised SPA submitted with this response.

12. In addition, the SPA explains that "payments will be made consistent with the level of funds established and amended by the General Assembly, which are published in the Long Bill and subsequent amendments each year." The language also indicates that "rate letters will document any change in the total funds available." This language implies that reimbursement and/or payment amounts under SPA 06-014 are contingent upon funding of the State share as determined by the legislature. This language does not represent a comprehensive reimbursement method and must be removed from the State plan. If the State does not anticipate a source of State share for the payments under SPA 06-014 in future years, the State must amend SPA to end date the payments or delete the supplemental payment methodology in years where there is no available source of State share.

Response

The original language was developed with the assistance of CMS (the NIRT) several years ago. This language is consistent with language included with all other Supplemental Medicaid payment methodologies (including DSH payments) in the State Plan, Attachment 4.19-A. However, the revised SPA submitted with this RAI has deleted most of this language.

This payment is the last payment type available on a tiered payment system. The language in the SPA is intended to convey that message. We believe it is imperative that the following language be included in the SPA to protect providers.

"The Local Government Outpatient Hospital payment shall be made only if there is available federal financial participation under the Medicare Upper Payment Limit after the Medicaid reimbursement." This language is located in the last sentence of the second paragraph in section A of the SPA.

Upper Payment Limit Demonstration

Federal regulations at 42 CFR 447.321 require States to demonstrate that Medicaid payments for outpatient hospital services do not exceed a reasonable estimate of what Medicare would pay for equivalent services. Please provide a demonstration that payments under SPA 06-014 are in

compliance with the Medicaid upper payment limit (UPL) for outpatient hospital services. Payments made by Medicaid for outpatient hospital services, which are compared to an estimate of what Medicare would pay for equivalent services, must include all base and supplemental outpatient hospital payments reimbursed under the State plan. The UPL demonstration is conducted in the aggregate for all privately owned, State owned governmental and non-State owned governmental facilities.

13. Please explain how the State determines its outpatient hospital services upper payment limit, including references to the Medicare Cost Report, data sources (i.e. MMIS charge data), how the data is trended, and how the State determines the UPL category of each provider. CMS will review each component of the UPL to assure that it provides a reasonable estimate of the amount Medicare would reimburse for these services.

    Response

    The Medicare Outpatient Upper Payment Limit (UPL-O) is the maximum Medicaid can reimburse providers and still receive a federal match. The UPL-O must be a reasonable estimate under current conditions; it does not represent actual Medicaid reimbursement for the request year, Medicaid provider costs, or potential Medicare reimbursement. A separate calculation is necessary for State-owned government, non-state owned government and privately-owned facilities. Please see the response to question 14 for additional information on how the UPL-O is calculated.

14. Does the State intend to demonstrate the UPL on the basis of Medicare cost or Medicare payment for equivalent O/P hospital services? Please provide the formula used to calculate the reasonable estimate that Medicare would pay for equivalent Medicaid services.

    Response

    The State intends to demonstrate the UPL on the basis of Medicare cost. The annual calculation for the UPL-O by Medicaid facility would be as follows:

    1. ***Medicaid Charges * Facility Specific Cost-to-Charge Ratio * 72% = Medicaid Reimbursement***
    2. ***Medicaid Charges * Facility Specific Cost-to Charge Ratio = Medicare Reimbursement***
    3. ***(Maximum Allowable Medicare UPL-O Percentage * Medicare Reimbursement) – Medicaid Reimbursement = UPL-O***

    Such that,

    1. ***Medicaid Charges are the outpatient charges by facility as reported by MMIS. These figures will contain a lag to be inflated forward to the current year using the Medicaid caseload forecast, based on the CPI – U.S. City Average for Medical Care. In addition, the fee-for-service charges will be modified to include changes in HMO enrollment.***
    2. ***Facility Specific Cost-to-Charge Ratio is the cost-to-charge ratio for outpatient services as determined by the auditing of each facility's Medicare/Medicaid Cost Reports.***

15. Inclusive of all privately owned, state governmental, and non-state governmental hospitals, please provide a spreadsheet that details the O/P hospital UPL for each hospital within each ownership category. The spreadsheet data must include enough detail to clearly demonstrate that in the aggregate Medicaid payments for each category of hospitals falls below the UPL.

Response

The calculation by provider is attached to the response as Attachment A.

16. If the State plans to include clinical diagnostic laboratory services in its outpatient hospital services UPL, then it must show this as a separate calculation. These services are subject to a separate UPL test 1903(i) of the Social Security Act, which requires that payment not exceed the Medicare rate *on a per test basis.* To help the State identify charges for these services, it may refer to the 80000 series of CPT codes.

Response

The State does not plan on including clinical diagnostic laboratory services in its outpatient hospital services UPL.

17. Do all facilities included in the UPL demonstration meet the definition of provider-based in accordance with 42 CFR 413.65?

Response

Yes, all the facilities included in the UPL demonstration are hospitals that are licensed by the Colorado Department of Public Health and Environment.

Questions regarding source of funding

1. Section 1903(a) (1) provides that federal matching funds are only available for expenditures made by states for services under the approved State Plan. To ensure that program dollars are used only to pay for Medicaid services, we are asking states to confirm to CMS that providers retain 100 percent of the payments provided for in this SPA. Do providers retain all of the Medicaid payments (including regular and any supplemental payments) including the federal and State share, or is any portion of any payment returned to the State, local governmental entity, or any other intermediary organization? If providers are required to return any portion of any payment, please provide a full description of the repayment process. Include in your response a full description the methodology for the return of any of the payments, a complete listing of providers that return a portion of their payments, the amount or percentage of payments that are returned and the disposition and use of the funds once they are returned to the State (i.e., general fund, medical services account, etc.).

Response

In regards to this SPA, providers will receive and retain 100% of the local government outpatient payments. Under the State Plan, hospitals receive a Medicaid payment for Outpatient Hospital Services; additionally, State-owned and non-state owned government facilities receive a Supplemental Medicaid Payment. The provider retains the federal and state share of the Medicaid payment. The state share of the Supplemental Medicaid payment is funded through certification of public expenditures. Providers voluntarily allow the Department to retain the federal share of the Supplemental Medicaid payment in order to mitigate the need to reduce Medicaid reimbursement rates. The federal share is retained in the Department's budget within the Medical Services Premium line item, which is used to fund Medicaid payments.

In FY 2006-07, the federal share of the Supplemental Medicaid payments to State and non-state government owned hospitals retained by the Department is listed below:

Provider Name	State Share	Federal Share	Total Supplemental Payment
Colorado Mental Health Institute - Pueblo	$0	$0	$0
Colorado Mental Health Institute – Ft. Logan	$0	$0	$0
University of Colorado Hospital	$3,314,862	$3,314,862	$6,629,724
State-Owned Government Hospital Total	**$3,314,862**	**$3,314,862**	**$6,629,724**
Aspen Valley Hospital	$57,563	$57,563	$115,126
Delta County Memorial	$80,838	$80,838	$161,676
Denver Health Medical Center	$3,493,430	$3,493,430	$6,986,860
East Morgan County Hospital	$76,890	$76,890	$153,780
Estes Park Medical Center	$24,551	$24,551	$49,102
Grand River Hospital District	$128,820	$128,820	$257,640
Gunnison Valley Hospital	$73,027	$73,027	$146,054
Haxtun Hospital District	$22,086	$22,086	$44,172
Heart of the Rockies Regional Medical	$113,061	$113,061	$226,122
Keefe Memorial Hospital	$2,009	$2,009	$4,018
Kit Carson County Memorial Hospital	$636,156	$636,156	$1,272,312
Kremmling Memorial	$46,729	$46,729	$93,458
Lincoln Community Hospital and Nursing	$58,279	$58,279	$116,558
Melissa Memorial Hospital	$31,339	$31,339	$62,678
Memorial Hospital – Colorado Springs	$795,996	$795,996	$1,591,992
Montrose Memorial Hospital	$121,398	$121,398	$242,796
North Colorado Medical Center	$755,314	$755,314	$1,510,628
Pioneers Hospital	$27,861	$27,861	$55,722

Poudre Valley Hospital	$335,254	$335,254	$670,508
Prowers Medical Center	$131,278	$131,278	$262,556
Rangely District Hospital	$17,517	$17,517	$35,034
Sedgwick County Memorial Hospital	$8,080	$8,080	$16,160
Southeast Colorado Hospital and LTC	$12,644	$12,644	$25,288
Southwest Memorial Hospital	$210,866	$210,866	$421,732
Spanish Peaks Regional Health Center	$43,356	$43,356	$86,712
St. Vincent General Hospital District	$61,788	$61,788	$123,576
The Memorial Hospital - Craig	$36,541	$36,541	$73,082
Weisbrod Memorial County Hospital	$8,898	$8,898	$17,796
Wray Community District Hospital	$46,906	$46,906	$93,812
Yuma District Hospital	$116,932	$116,932	$233,864
Non-State Owned Government Hospital Total	**$7,575,407**	**$7,575,407**	**$15,150,814**
Grand Total	**$10,890,269**	**$10,890,269**	**$21,780,538**

2. Section 1902(a)(2) provides that the lack of adequate funds from local sources will not result in lowering the amount, duration, scope, or quality of care and services available under the plan. Please describe how the state share of each type of Medicaid payment (normal per diem, supplemental, enhanced, other) is funded. Please describe whether the state share is from appropriations from the legislature, through intergovernmental transfer agreements (IGTs), certified public expenditures (CPEs), provider taxes, or any other mechanism used by the state to provide state share. Please provide an estimate of total expenditure and State share amounts for each type of Medicaid payment. If any of the non-federal share is being provided using IGTs or CPEs, please fully describe the matching arrangement including when the state agency receives the transferred amounts from the local government entity transferring the funds. If CPEs are used, please describe the methodology used by the state to verify that the total expenditures being certified are eligible for Federal matching funds in accordance with 42 CFR 433.51(b). For any payment funded by CPEs or IGTs, please provide the following:

   (i) a complete list of the names of entities transferring or certifying funds;
   (ii) the operational nature of the entity (state, county, city, other);
   (iii) the total amounts transferred or certified by each entity;
   (iv) clarify whether the certifying or transferring entity has general taxing authority: and,
   (v) whether the certifying or transferring entity received appropriations (identify level of appropriations).

Response

The following table documents the payments for Outpatient hospital services under Attachment 4.19-B and provides expenditures for FY 2006-07:

Payment Type	Source of State Share	State Share	Total Expenditure
Medicaid Payment (as defined in Attachment 4.19B and paid under the Medicaid program)	Appropriations from the Legislature	$57,883,637	$115,767,274
Supplemental Medicaid Payment	Certified Public Expenditure	$10,890,269	$21,780,538
Local Government Outpatient Hospital Payment (Estimate)	Provider Assessment	$1,467,059	$2,934,118

The State share of the Medicaid payment is funded through appropriations from the legislature. The State share of the Supplemental Medicaid payment is funded through Certified Public Expenditures (CPE). The CPE is uncompensated Medicaid costs related to outpatient hospital services, certified by State-owned and non-state owned government hospitals. These public hospitals certify that the annual uncompensated Medicaid costs reported represent expenditures eligible for FFP under 42 CFR 433.51(b). A hospital must certify their acknowledgement that federal regulations prohibit their facility from receiving further reimbursement of federal funds on the amounts certified and declare that none of the CPE contains federal dollars. In addition, the hospital must certify that funds, other than federal funds, are sufficient and available to cover the State's portion of the match for the uncompensated Medicaid costs certified.

Attachment B lists the names of entities certifying funds, the operational nature of the entity (State, county, city, other), the FY 2006-07 amounts certified by each entity; whether the certifying entity has general taxing authority, and whether the certifying entity received appropriations. There are no intergovernmental transfer agreements (IGTs) associated with these payments.

3. Section 1902(a) (30) requires that payments for services be consistent with efficiency, economy, and quality of care. Section 1903(a) (1) provides for Federal financial participation to States for expenditures for services under an approved State plan. If supplemental or enhanced payments are made, please provide the total amount for each type of supplemental or enhanced payment made to each provider type in the waiver.

Response

For State FY 2006-07 the Supplemental Medicaid payment by provider type was as follows:

Supplemental Medicaid Payment	Type of Facility	Total Expenditure	State Share
Certified Public Expenditure	State-owned government facilities	$6,629,724	$3,314,862

Certified Public Expenditure	Non-state owned government facilities	$15,150,814	$7,575,407
	Total	$21,780,538	$10,890,269

4. Does any public provider receive payments (including regular and any supplemental payments) that in the aggregate exceed its reasonable costs of providing services? If payments exceed the cost of services, does the State recoup the excess and return the federal share of the excess to CMS on the quarterly expenditure report?

Response

No public provider receives payments that in the aggregate under Attachment 4.19-B (normal per-diem, DRG, DSH, supplemental, enhanced, other) exceed their reasonable costs of providing services. The Department makes no payments to public providers that exceed the cost of services, so no recouping of the excess to CMS is necessary.